DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-008

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 0
b. FFY 2003 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 4.19-B, pg 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 1 to Attachment 4.19-B, pg 3

10. SUBJECT OF AMENDMENT:

technical correction to clarify Plan description of Medicare crossover processing methodology in place since July, 2002

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Melanie Bella

13. TYPED NAME: Melanie Bella

14. TITLE: Assistant Secretary, Medicaid Policy & Planning

15. DATE SUBMITTED: 11/24/04

16. RETURN TO:
Melanie Bella, Assistant Secretary
Indiana Office of Medicaid Policy and Planning
402 West Washington, Room W382
Indianapolis, IN 46204
ATTN: Tracy Brunner, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11/30/04

18. DATE APPROVED: 1/11/05

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/02

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
NOV 30 2004
DMCH - IL/IN/OH

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Cross-over claims filed by Medicaid providers are reimbursed as set out in this section.

   If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero.

   If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

   (a) the difference between the Medicaid allowable amount minus the Medicare payment amount; or
   (b) the Medicare coinsurance and deductible, if any, for the claim.

For purposes of cross-over reimbursement, a claim is the same as an ICN (Individual Claim Number) which is the payment requested on one paper document or electronic record for services provided during a particular date range for which there are one or more revenue or HCPCs codes.